Filed for intro on 01/31/2002
HOUSE BILL 2894 By
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SENATE BILL 2941
By Clabough

AN ACT to amend Tennessee Code Annotated Section 56-32-226 relative to independent review.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-226 is hereby amended by deleting subsection (b) in its entirety and substituting the following language:

(b) This subsection is intended to ensure the prompt and accurate payment of all provider claims for services delivered to an enrollee in the TennCare program which are submitted to a health maintenance organization involved in a TennCare line of business or a subcontractor of that organization. Accordingly, each such organization or subcontractor must establish and implement the following procedures for the processing of provider claims and the resolution of any disputes regarding the payment of such claims:

(1) The health maintenance organization shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are processed, and if appropriate paid within thirty (30) calendar

days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. If a provider agreement requires the health maintenance organization to pay a provider a capitated payment each month, such payment shall be made by the time specified in the contract between the provider and the health maintenance organization. If the contract between the provider and health maintenance organization does not specify a payment schedule, payment shall be made by the tenth (10^{th}) day of each calendar month. Disputed capitated provider payments are subject to independent review.

(A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation.

(2)(A) If a provider's claim is partially or totally denied in a remittance advice or other appropriate written notice, then the provider may send a written request for reconsideration to the health maintenance organization within sixty (60) calendar days of the receipt of the partial or total denial of the claim. The reconsideration request should include any documentation or information requested by the health maintenance organization. The health maintenance organization must respond to the reconsideration request within sixty (60) calendar days after receipt of the request. If the health maintenance organization continues to deny the provider's claims or the health maintenance organization does not respond within sixty (60) calendar days of receipt of the request, then the provider may file a written request to submit the claims denial to an independent reviewer for review as provided herein at subdivision (b)(3).

(B) If a provider elects to request independent review, the provider shall, at a minimum, provide the commissioner the information required by the commissioner. The commissioner shall provide the provider in writing the information required.

(C) In order for a claim to be eligible for independent review, a provider must request independent review within sixty (60) calendar days of the initial denial of the claim. If the provider requests reconsideration, it must request independent review within thirty (30) calendar days of the health maintenance organization's denial of the reconsideration request. However, if the provider requests reconsideration and the health maintenance organization does not respond within the sixty (60) calendar day time limit, the provider must request independent

review within thirty (30) calendar days of the due date of the health maintenance organization's response to the reconsideration request.

(D) Claims payment disputes involved in litigation or arbitration are not eligible for independent review.

(3) Each health maintenance organization operating a TennCare line of business must contract with independent reviewers selected in accordance with subdivision (b)(4), and implement the following procedures to resolve disputed provider claims:

(A) When the commissioner receives a written request for review of a disputed provider claim, the commissioner shall refer the claim for review to an independent reviewer on the health maintenance organization's contracted reviewer panel. The Department of Commerce and Insurance shall use its best efforts to refer an equal proportion of total annual disputed claims to each independent reviewer. The reviewer shall, within fourteen (14) calendar days of receipt of the disputed claim, request in writing that both the provider and the health maintenance organization provide the reviewer any and all information and documentation regarding the disputed claim. The provider and health maintenance organization must provide the independent reviewer with such information or documentation within thirty (30) calendar days of receipt of the reviewer's request or the reviewer will not consider it. The reviewer shall also advise the provider and health maintenance organization that the reviewer will not consider any information or documentation from the provider that the provider did not submit to the health maintenance organization during that organization's review of the provider's disputed claim. The reviewer shall then examine all material submitted and render a decision on the dispute within sixty (60) calendar days of receipt of the disputed claim, unless the reviewer requests guidance on a medical issue from the TennCare appeals unit.

(B) Should the reviewer need assistance on a medical issue connected with the disputed claim, then the reviewer shall refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the TennCare Bureau, Department of Finance and Administration, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may respond to the request, refer the request to an independent contractor, or refer the request to the TennCare Bureau for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one (1) or more states in the United States. The appeals unit shall provide a concise response to the request within ninety (90) calendar days after receipt. If the appeals unit seeks the guidance of the TennCare Bureau on whether a benefit is a covered service, then the Bureau must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer shall make a final decision within thirty (30) calendar days of receipt of the appeals unit's response.

(C) The reviewer shall send the health maintenance organization, the provider, and the TennCare Division of the Department of Commerce and Insurance a copy of the decision. Once the reviewer makes a decision requiring a health maintenance organization to pay any claim or portion thereof, then the health maintenance organization must send the payment in full to the provider within twenty (20) calendar days of receipt of the reviewer's decision. If the health maintenance organization does not pay a provider in accordance with an independent review decision within twenty (20) calendar days of receipt of the decision, the TennCare Division of the Department of Commerce and Insurance

may notify the TennCare Bureau of the health maintenance organization's noncompliance. The TennCare Division may also request the TennCare Bureau to withhold from the capitation payment due the health maintenance organization the amount owed to the provider pursuant to the independent review decision. In addition, the TennCare Division may also request the TennCare Bureau to make payment directly to the provider out of the health maintenance organization's withhold.

(D) Within sixty (60) calendar days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not brought within sixty (60) calendar days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be de novo without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching a decision, shall be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney's fees and expenses from the non-prevailing party. "Reasonable attorney's fees" means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or five hundred dollars ($500), whichever amount is greater.

(E) In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim. For all claims filed on or after October 1, 1999, the State may not mandate that the provider and health maintenance organization resolve the claims payment dispute through arbitration.

(F) Providers who are owned by state or local governmental entities shall retain the statutory right of setoff if available. Judicial review of a reviewer's decision regarding a state or local governmental provider shall be in the chancery court of Davidson County, and not in the Tennessee Claims Commission, unless the provider and health maintenance organization have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney's fees and expenses awarded under subdivision (b)(3)(D).

(G) All costs associated with implementing these procedures shall be paid by the applicable health maintenance organization. However, the provider shall reimburse the health maintenance organization the independent reviewer's fee within twenty (20) calendar days of receipt of the reviewer's decision, if the reviewer finds that the health maintenance organization properly denied the claim being reviewed. If a provider fails to properly reimburse the health maintenance organization, the TennCare Division of the Department of Commerce and Insurance may prohibit that provider from future participation in the independent review process.

(H) The health maintenance organization shall pay any appropriate bill submitted by an independent reviewer within thirty (30) calendar days of receipt of the bill. If

the health maintenance organization fails to pay any such bill, then the reviewer may request payment directly from the state from any funds held by the state that are payable to the health maintenance organization.

(I) The above procedures shall apply to all claims filed for the first time on or after October 1, 1999.

(4) The commissioner shall appoint a panel of five (5) persons, known as the TennCare Claims Processing Panel. The panel shall consist of two (2) provider representatives, one (1) representative from each of the two (2) health maintenance organizations with the largest number of TennCare enrollees, and the deputy commissioner of the TennCare Division in the Department of Commerce and Insurance or his or her designee. If either of the largest health maintenance organizations declines to serve, the commissioner shall select another TennCare health maintenance organization to serve. All decisions of the panel shall be made by a majority vote of the members of the panel. The panel shall select and identify an appropriate number of independent reviewers to be retained by each health maintenance organization under subdivision (b)(3). The panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each health maintenance organization engaged in a TennCare line of business, as a condition of participating as a contractor in the TennCare program, shall contract with each reviewer and agree to pay the rate of compensation negotiated by the panel. The expenses of this panel shall not be compensated by the state.

(5) By no later than May 1 of each year, the commissioner shall report to the Department of Health and to the Fiscal Review Committee the number of requests for TennCare claims review filed for each health maintenance organization operating a TennCare line of business during the prior calendar year. The commissioner shall

also generally report the outcome of these independent review requests for each health maintenance organization. In addition, the commissioner shall report the name of any provider whose claim denial is upheld in more than fifty percent (50%) of the independent review requests, as well as the number of claim reviews with the claims denial upheld for that provider.

(6) All claims for services furnished to a TennCare enrollee filed with a health maintenance organization must be processed by either the health maintenance organization or by a single subcontractor retained by the organization for the purpose of processing claims. However, another single entity can process claims related to each of the following: pharmacy, vision, dental or mental health benefits.

(7) The health maintenance organization shall ensure all its subcontractors processing TennCare claims follow the same claims processing and resolution procedures required by the Prompt Pay Act. TennCare claims processed by a subcontractor are subject to the prompt payment requirements of this statute. Claims denied by a subcontractor are subject to independent review. If a provider requests independent review of a claim denied by a subcontractor, the health maintenance organization contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the health maintenance organization the reviewer's fee. If the independent reviewer finds for the provider, the health maintenance organization contracted with the subcontractor must pay the provider.

(8) A health maintenance organization that subcontracts with another entity to obtain services for TennCare enrollees shall guarantee and assure the payment of all contracted amounts agreed to be paid to such providers by that entity or that entity's agent. This does not preclude the health maintenance organization from seeking reimbursement from the subcontractor for any amounts paid. Nor does this prevent

the health maintenance organization from asserting any legal defenses to the payment of a provider's claims that were available to the subcontractor. Claims filed with a subcontractor are subject to the prompt payment requirements of this statute. Claims denied by a subcontractor are subject to independent review. If a provider requests independent review of a claim denied by a subcontractor, the health maintenance organization contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the health maintenance organization the reviewer's fee. If the independent reviewer finds for the provider, the health maintenance organization contracted with the subcontractor must pay the provider.

(9) Any health maintenance organization found by the commissioner to be in violation of Tenn. Code Ann. § 56-32-226(b) shall be subject to revocation or suspension of its certificate of authority under Tenn. Code Ann. § 56-32-216 or, in the alternative, the imposition of the penalties and other remedies set forth at Tenn. Code Ann. § 56-32-220.

SECTION 2. The purpose of this Act is to clarify the administration of independent review.

SECTION 3. This Act shall become effective July 1, 2002, the public welfare requiring it.